CAREGIVER CONSULTING, INC.
P: 786-514-9177 F: 1-866-209-0444
www.caregiverconsulting.com
E-mail: caregiverconsulting@hotmail.com

Data Collection Sheet for AHCA's Proof of Financial Ability to Operate

DATE: ______________________

Consultant Name: __________________________

Consultant Phone: __________________________

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Call 786-514-9177 if you have questions.

FAX WHEN COMPLETED TO: CAREGIVER CONSULTING, INC. (866) 209-0444

NURSE REGISTRY INFORMATION FOR AHCA FINANCIALS

Facility Name: ____

Address: ____

City: ________________________________ FL. Zip Code________________________

Telephone: ____________________ Fax: ________________ County: ____________

Facility Type: NURSE REGISTRY; Total Clients expected in Year 1: ___________

Owner's Name ____

Administrator's Name ____

Is Admin an RN? _______ Is Admin the Financial Officer for the Registry? __________

Is Alt. Admin an RN? _______ Expected Application Filing Date: __________________

Contact Phone: _________________________________ Fax: _____________________

Contact Email(s): ____

IMPORTANT NOTICE

THE PFA WILL BE DONE IN 72 - 96 HOURS, AFTER WE RECEIVE THIS COMPLETED FORM. WE REQUIRE A 50% DEPOSIT IN ADVANCE. THE 50% BALANCE IS DUE WHEN THE DOCS ARE COMPLETED, PRIOR TO DELIVERY. PAYMENT BY ZELLE IS PREFERRED, BUT WE ALSO ACCEPT CREDIT AND DEBIT CARD PAYMENTS. A CREDIT CARD AUTHORIZATION IS ON THE NEXT PAGE. THERE IS NO COST FOR CORRECTIONS WITHIN 30 DAYS OF DELIVERY. IT'S $250 FOR UPGRADES AFTER 30 DAYS.

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COST AND CERTIFICATION OF INFORMATION PROVIDED

COST OFSERVICE: **Nurse Registry Financials + Notes & Assumptions** **$750.00**

Additional Cost of Addressing Omission for PFA prepared by others **$250.00**
Additional Cost of Addressing NOIDWs for PFA prepared by others **$300.00-$475.00**

OPTIONAL SERVICES: AHCA might require the following optional documents. Check any that you would like us to provide for you.

Nurse Registry Lease	$75.00	☐
Bill of Sale + Seller's Affidavit (if Change of Ownership)	$125.00	☐
Furniture Donation Affidavit	$50.00	☐

TOTAL ____________

CERTIFICATION

I, the undersigned, certify that the financial information provided above and below in this questionnaire, for the Agency for Health Care Administration (AHCA) and Department of Elder Affairs (DOEA), is true and correct to the best of my knowledge. I understand AHCA might ask for more information or receipts and can deny my application if it determines that any of the information I provide is insufficient or unacceptable.

Signature of Owner, Administrator or Manager ____________ PRINT NAME ____________ Date ____________

Pay by Zelle to Caregiver Consulting, Inc. using 786-514-9177

FILL IN BELOW FOR PAYMENT BY CREDIT OR DEBIT CARD

PAYMENT AUTHORIZATION TO CAREGIVER CONSULTING, INC.			**Amount:**	
Card Type	☐**Visa** ☐**MasterCard** ☐**Discover** ☐**Amex**		**Date Expire**	
Card Number			**CCV:** 3 digits; 4 if American Express	
Name on Card				
Cared Zip Code		**Phone Number**		
Signature			**Date Signed**	

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LIST THE FOLLOWING MONTHLY EXPENSES WITH COMMENTS IF ANY		
Item	**Monthly Amt.**	**Comments (if any)**
Rent/Mortgage		
Utilities (phone, water, etc.)		
Insurance (if paid monthly)		
Account/Bookkeeper		
Loan + Interest payments		
Equipment lease payment		
Inventory		
Supplies (office + medical)		
Education/Training		
Repair/Maintenance		
Other		

WRITE A STATEMENT DESCRIBING HOW YOU INTEND TO GET CLIENTS

____

____

____

IMPORTANT: STATE THE % OF YOUR REVENUES THAT WILL COME FROM THE FOLLOWING:

Private Pay	Medicaid Waiver	Insurance	HMO/PPO

MARKETING & ADVERTISING		
M&A Type	**Expected Cost**	Comments if any
New Website		
Flyers/Postcards/Brochures		
Print Media (newspapers, etc.)		
Broadcast Media		
Other		

IF THIS IS A CHOW: PURCHASE PRICE HERE $____________________

If paying bye a loan: Loan Amount: _________________ Interest Rate: _____% No. of Years ____________
STOP HERE.

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If not a CHOW, please complete this page:

FILL IN THE AMOUNTS YOU PAID EXACTLY AS THEY APPEAR ON THE RECEIPTS (E.G. 245.86). DON'T LIST ITEMS THAT YOU DON'T HAVE RECEIPTS FOR

EQUIPMENT PURCHASES		
Office Renovation Cost	**Amount Paid if Work Already Done**	Amount To be Paid if work not already done
Office Equipment (Describe each)	**Amount Paid if Already Purchased**	Amount To be Paid if not Purchased
Furniture	**Amount Paid if Already Purchased**	Amount To be Paid if not Purchased
Other Expenses	**Amount Paid if Already Paid**	Amount To be Paid if not Purchased

Fax the completed datasheets to us at 1-866-209-0444

OR you can email it to **caregiverconsulting@hotmail.com**